85-613

Supreme Court, U.S.
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No.

In the Supreme Court of the United States

October Term, 1985

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., a non-profit corporation,

Petitioner,

v.

THE TRAVELERS INSURANCE COMPANIES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED

1. Whether the sovereign immunity of the United States extends to an independent contractor/fiscal intermediary to render the contractor and its employees immune from liability for unauthorized acts for which liability otherwise would exist under applicable state law.

2. Whether the Constitution of the United States precludes the extension of sovereign immunity of the United States to an independent contractor and its employees for tortious acts committed outside the scope of their authority.

3. Whether the prior decision of this Court in the instant case that the United States was not properly estopped from recovering Medicare overpayments was intended by this Court to preclude a tort claim for damages arising under the applicable laws of the Commonwealth of Pennsylvania against Travelers Insurance Companies where this Court concluded that Travelers had neither actual nor apparent authority with regard to acts which it committed as a consequence of which the United States could not be estopped from recovering Medicare overpayments.

PARTIES TO THE PROCEEDINGS

In addition to the parties named in the caption, the Secretary of Health and Human Services, then Joseph A. Califano, Jr., was an appellee in the Court of Appeals and Ada Werner, Frank E. Werner and Shirley Sorger, individuals, were appellants.

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No.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

AND NOW comes Community Health Services of Crawford County, Inc. ("CHS"), through its undersigned attorneys and petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinions of the court of appeals (Appendix A, 1a-2a), the district court (Appendix C, 4a-19a), and the Provider Reimbursement Review Board (Appendix D, 20a-27a) are not reported. A prior decision in this case by this Court at U.S. , 81 L.Ed.2d 42, on the issue of estoppel against the United States bears directly on this Petition.

JURISDICTION

The decision of the court of appeals (Appendix A, 1a-2a) was entered on August 7, 1985. A petition for rehearing was denied on September 3, 1985 (Appendix B, 3a). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE AND REGULATIONS

There are none.

STATEMENT OF THE CASE

Petitioner commenced its first action (C.A. 78-74 Erie) to prevent the Secretary of Health and Human Services ("Secretary") through her agent, Intermediary Travelers Insurance Companies ("Travelers"), from withholding future Medicare reimbursement payments owed to petitioner CHS, a non-profit home health care agency, because Travelers alleged that CHS had been overpaid for Medicare services rendered during its cost years 1975, 1976 and 1977. Prior to bringing the action, CHS requested that the Secretary waive any recoupment of the alleged overpayments because CHS was without fault and, when that was

denied, CHS requested an administrative hearing before the Provider Reimbursement Review Board ("PRRB"). Because of the continuing threat to withhold funds, petitioner sought a Temporary Restraining Order which was granted by the district court. Thereafter, agreement was reached with the Secretary and Travelers to hold in abeyance any recoupment activity pending final resolution of the dispute. A stipulation for a stay in the district court action was entered to permit CHS to proceed with its hearing before the PRRB.

The hearing before the PRRB was limited because of the jurisdiction of the PRRB. See 42 C.F.R. § 405.1873 and 42 C.F.R. § 405.1869. The Board had no authority to consider the question of Travelers' liability for actions which were outside of its authority. That issue along with several other issues not within the PRRB's jurisdiction and therefore not considered by the PRRB was preserved and raised *de novo* in CHS' appeal to the United States District Court for the Western District of Pennsylvania in C.A. 80-56B Erie.

In the district court, the Secretary, including Travelers, and CHS filed cross-motions for summary judgment. The district court denied CHS' motion and granted the Secretary's and Travelers'. See district court decision, Appendix C, pages 4a-19a of petition.

Respondents appealed from the district court decision raising various questions including estoppel against the United States and the following question with regard to Travelers:

> 2. Whether the District Court erred in finding that Travelers, as Intermediary for the United States, did not act outside the scope of its authority in advising

> CHS and inducing CHS' reliance and, therefore, never decided whether Travelers should be held liable to CHS and/or the United States for payments to CHS which Travelers approved?

Brief for Appellants in the United States Court of Appeals for the Third Circuit No. 82-5098.

On August 7, 1985, the court of appeals, in a Judgment Order, vacated a prior judgment of the court of appeals entered on January 19, 1983 in favor of petitioner and simply affirmed the judgment of the United States District Court for the Western District of Pennsylvania entered on November 16, 1981 in favor of the Secretary and Travelers. The decision with regard to the January 1983 judgment is reported at 698 F.2d 615 (1983).

In the previous judgment entered on January 19, 1983 in favor of CHS, the court of appeals vacated and reversed the judgment of the district court (Appendix C, 4a-19a) but decided only that the United States was estopped from recovering the alleged overpayments to CHS of about $63,000 because of affirmative misconduct by Travelers acting as an agent for the government. The district court held that the United States was not estopped and, pertinent to this petition, that Travelers was immune from liability as the agent of the United States.

The foregoing judgment of the court of appeals with regard to the issue of estoppel was reversed by this Court on May 21, 1984, which remanded for further proceedings consistent with its Opinion. The issue resolved on the Secretary's petition for a writ of certiorari did not concern the issue of Travelers' liability and this petition does not concern the United States. The decision of this Court is reported at U.S. , 81 L. Ed. 2d. 42 (1984).

Not before this Court and left unresolved by the January 1983 decision of the court of appeals were a number of issues raised in the prior proceeding by CHS, particularly whether the summary judgment entered by the district court holding Travelers immune from liability should be vacated and reversed. (Appendix C, 16a).

Certiorari is sought only as to the Travelers' issue and the court of appeals did not make a statement of the law or explain the application of the law to the circumstances of the case in the August 7, 1985 judgment (Appendix A, 1a-2a) affirming the prior judgment of the district court. For the foregoing reasons, petitioner's recitation and argument are necessarily addressed to the decision of the district court and the prior decision of this Court and the application of the law to the circumstances of the case.

The judgment of the district court in favor of Travelers was entered on the basis that the undisputed acts of Travelers' agent Reeves with regard to CHS were *within* Travelers' authority (Appendix C, 17a) and, therefore, Travelers enjoyed governmental immunity. The district court's conclusion was premised on the fact—then asserted by the Secretary—that "Travelers acted as an agent of the government of the United States in making payments to CHS under the Medicare program" (Answer of the Secretary and her agent, Travelers Insurance Companies).

Before the district court, the Secretary contended that Travelers was, ". . . not personally liable to the provider for any incorrect advice given to the Provider by the Intermediary's Representative" (Brief in Support of Defendant's Motion for Summary Judgment). The Secretary's theory in support of the issue was that Travelers at all times acted

with authority but was excused for what the Secretary contended was a mere "mistake of judgment" in making false representations to CHS.

On the other hand, CHS contended that statements made to it were of facts and not mere opinions and for acts committed outside the scope of its authority, Travelers was independently liable to CHS. CHS filed a cross-motion for summary judgment against Travelers for acts outside of its authority.

On the motions for summary judgment, the district court stated the issue raised by CHS on the cross-motion as follows:

> Plaintiff [CHS] asserts that Travelers was acting ultra vires by deliberately and consciously misleading CHS on the cost accounting treatment of CETA funds when it knew that no government policy had been set forth and knew that its advice could not be substituted for that of the Secretary. Therefore, plaintiff believes that Travelers should be held independently liable to it for the overpayment. Appendix C, 16a.

However, the court concluded:

> In this case there is no question but that Michael Reeves gave incorrect advice to the provider and approved cost reports reflecting that erroneous advice. But there is no evidence of willful or wanton misconduct on the part of Mr. Reeves. It is inconceivable that the government could have an established policy for each and every possible grant received by a provider and it is expected that the intermediary will give its opinion on unexpected questions that arise. It is also expected that those opinions will not always coincide with the position of the Secretary. The regulations make it clear that it is the statutes themselves and the

> opinion of the Secretary which is controlling. It does appear that Mr. Reeves exercised poor judgment by waiting so long before checking with his superiors on the correct application of CETA funds. *However, as earlier stated, mistakes of judgment do not constitute activity outside the federal official's authority.* We find no basis for holding Travelers independently liable to plaintiffs. (Emphasis supplied). Appendix C, 17a.

The district court denied CHS's motion for summary judgment and granted judgment in favor of Travelers.

While the issue of Travelers' immunity was not decided by the court of appeals in the judgment of January 19, 1983, in its brief to that Court on the issue, at page 31, the Secretary stated:

> . . . Such action, however, did not constitute activity outside the scope of Travelers' authority as an intermediary . . . This mistake occurred while Travelers was carrying out its duties in administering the Medicare program and was corrected upon the advice of HHS.

It is therefore beyond dispute that the denial of CHS' cross-motion for summary judgment and the summary judgment entered by the district court in favor of Travelers and affirmed August 7, 1985, was and is premised on the Secretary's and Travelers' asserted fact and the district court's acceptance of the asserted fact, that Travelers acted under its authority in making representations to CHS with regard to the treatment by CHS of CETA grants. CHS disputed the facts and applicable law as an alternative position.

This Court in reversing the court of appeals' decision of January 1983 (698 F.2d 615), with regard to the estoppel issue found that, "Travelers had neither [actual or

apparent authority] with respect to the interpretation of the regulation in question." (Fn. 21, and Headnotes 14a, 14b, 15a and 15b, ____ U.S. ____, 81 L.Ed.2d at 55).

And, further, with regard to the duty of Travelers to CHS this Court stated:

> It is undisputed that the correct administrative practice required Travelers to refer respondent's [CHS] inquiry to the Department of Health and Human Services for a definitive answer. However, Travelers did not do this until August 7, 1977 . . .

Acting without authority the conduct of Travelers constituted an actionable misrepresentation to CHS and a breach of duty to CHS under the applicable laws of the Commonwealth of Pennsylvania.

The findings and conclusions by this Court were essential and necessary to reverse the January 1983 judgment of the court of appeals on the estoppel issue and were directly contrary to the position of the Secretary and Travelers on the record which formed the basis for the summary judgment in favor of Travelers and the denial of summary judgment for CHS against Travelers. Otherwise, Travelers' interpretation of the regulation would have bound the Secretary. Moreover, the findings and conclusions by this Court that Travelers' lack of authority were the same conclusions contended for by CHS in the alternative to the district court.

The district court relied on *Butz v. Economou*, 438 U.S. 478 (1978) in deciding that Travelers was immune, but *Butz* is authority only with regard to an agent acting within his authority. *Little v. Barreme*, 2 Cranch. 170, 2 L.Ed. 243 (1804) and *Bates v. Clark*, 95 U.S. 204, 24 L.Ed. 471 (1871) cited in *Butz* hold that an agent who acts

outside of his authority is not immune. Thus, if the United States could not be estopped, Travelers was at risk for liability.

As to CHS' damages, a misapprehension of facts surely must exist. The misapprehension is that CHS' employees receiving CETA grants necessarily had to provide care to Medicare beneficiaries or, alternatively, the belief that no possible way existed for CHS to receive CETA grants without the Secretary being entitled to an offset. Both views are incorrect. We emphasize that CHS provided care for persons not eligible for Medicare benefits and the income from such persons or on their behalf constituted a significant part of CHS' total income. This Court recognized the fact by the comment in footnote 4, ____ U.S. ____, 81 L.Ed.2d at 50. In fact, CHS had the right, power and authority to direct that all of the CETA employees serve only those patients who were not eligible for Medicare benefits. CHS was under no requirement to have CETA employees care for a single Medicare beneficiary. They could be cared for by non-CETA employees. And, under those circumstances, with CETA employees completely isolated from Medicare beneficiaries, it is clear beyond dispute that the Secretary could not claim the right to legally offset under Medicare regulations any part of CHS' CETA income. Thus, if the CETA employees had served only non-Medicare beneficiaries, the Secretary would never have been entitled to offset any part of CETA grants. Simply put, but for the unauthorized and false representations by Travelers, no CETA employees would have cared for Medicare beneficiaries and no offsetting issue would have arisen. Any belief that CHS had no right to retain the CETA funds and obtain full payment from

the Secretary is founded upon an erroneous perception of the situation.

The district court decided the motions for summary judgment based on the Secretary's admission of agency and the district court's conclusion that Travelers' acts were within its authority. The present record is insufficient to uphold non-liability on the part of Travelers, but the record is sufficient to demonstrate beyond dispute Travelers' liability to CHS for which relief should be granted.

As a matter of law the district court committed clear and prejudicial error in holding Travelers immune from liability and not granting relief to CHS, and the court of appeals sanctioned a departure from the accepted and usual course of judicial proceedings by affirming the district court decision without opinion.

CHS may be faced with bankruptcy or some other equally unpleasant alternatives unless given a day in court against Travelers.

CHS contends that in light of the decision of this Court, the district court's denial of CHS' cross-motion for judgment and the entering of judgment holding Travelers immune from liability must be reversed and the case remanded for further proceedings on CHS' cross-motion consistent with the prior decision of this Court and applicable law; otherwise, a manifest injustice will result. There cannot be a rational basis for the judgment in favor of Travelers when this Court has found that Travelers acted without actual or apparent authority.

Alternatively, CHS contends the judgment of the district court's finding Travelers not liable was based upon disputed facts; *i.e.*, whether the false statements were

intentional, willful, wanton and reckless or merely negligent; hence, not a matter for summary judgment. Alternatively, the findings were clearly erroneous and CHS' motion should have been granted, at least to the extent of holding that Travelers was not immune from liability.

REASONS FOR GRANTING THE PETITION

It is beyond dispute that an immunity defense may exist only for acts and omissions within the agent's authority, and for unauthorized acts there is no immunity. *Little v. Barreme*, 2 Cranch. 170, 2 L. Ed. 243 (1804); *Bates v. Clark*, 95 U.S. 204, 24 L. Ed. 471 (1877); *Bushman v. Seiler*, 755 F.2d 653 (8th Cir. 1985).

Bates concerned the seizure of whisky in Indian country by military officers under a writ from the proper court. The court determined that the place of seizure was not Indian country and that there was no authority whatever to seize the property. The court went on to explain its affirmation of judgment against the military officers as follows:

> So the plea, that they had good reason to believe that this was Indian country and that they acted in good faith, while it might excuse these officers from punitory damages, is no defense to the action. If it had been Indian country, and it had turned out that the plaintiffs had a license, or did not intend to sell or introduce the goods, the fact that defendants acted on reasonable ground would have exempted them from liability.
>
> But the objection fatal to all this class of defenses is that in that locality they were utterly without any authority in the premises; and their honest belief that they had is no defense in their case more than in any

> other, where a party mistaking his rights commits a trespass by forcibly seizing and taking away another man's property.
>
> There was here no process from a competent court, nor any order from any source having authority, and there is, therefore, no defense.

Here, as in *Bates*, this Court found that Travelers had no authority. ____ U.S. ____, 81 L. Ed. 2d at 55.

The principles of federal law which this Court applied to the estoppel issue against the United States have no application to Travelers for a tort claim for damages arising under state law. The claim between CHS and Travelers is based upon diversity of citizenship and the amount in controversy. Under the law of Pennsylvania, the victim of a misrepresentation of fact (treatment of CETA funds and authority to bind the Secretary) may rely upon its truth even though he might have learned of the falsity of the representation if he had made an investigation (gone directly to the Secretary). *Bowman v. Home Life Insurance Company of America*, 260 F.2d 521 (3rd Cir. 1958). Further, Pennsylvania considers the disparity between the parties (Travelers and US v. CHS), *Siskin v. Cohen et al.*, 363 Pa. 580 (1950), and that a victim may be induced not to investigate (repeated assurances by Travelers/Reeves, payments and repeated audit approvals by Travelers), *Abrams v. Crown*, 178 Pa. Super. 407, 116 A.2d 331 (1955). Also, it is to be noted that under the law of Pennsylvania, the matter of justifiable reliance is viewed as the equivalent of contributory negligence (failure to exercise ordinary care) and is not a defense for making false representations (CHS case) except in very limited situations. *Bowman v. Home Life Insurance Company of America, supra*, at 522.

Neither willful nor wanton misconduct is required for liability. Pennsylvania law permits a recovery both for negligent as well as intentional misconduct when such conduct damages the business interests of another. The basis for a recovery for intentional misconduct, such as in fraud or deceit, is well established; and, in *Mill-Mar, Inc. v. Stathan*, 278 Pa. Super. 296, 420 A.2d 548 (1980), the Pennsylvania Superior Court examined and adopted *Restatement of Torts 2d*, Section 552, as the law of Pennsylvania. Section 552 provides a remedy for mere negligence in supplying false information to another even if there is no privity between the wrongdoer and the party wronged. Under Pennsylvania law, an award of punitive damages may be upheld even without a specific award of compensatory damages. *See Laniecki v. Polish Army Veterans Ass'n.*, 480 A.2d 1101 (Pa. Super. 1984). In a recently reported trial court decision, *Peterson v. State Farm Insurance Co.*, 133 P.L.J. 437 (Allegheny County, Pa. 1985), the court made reference to the following statement from *Darner Motor Sales v. Universal Underwriters Insurance Co.*, 140 Ariz. 383, 682 P.2d 388 (1984), in supporting the trial court's decision:

> We are a nation which also prides itself on a tradition of allowing a person to rely upon the words of another who, because of special knowledge, undertakes to act as an advisor. If an agent has an economic self-interest in imparting information, sound policy does require that the agent's duty to speak without negligence be reinforced by basic tort principles inherent in the common law. See *Restatement (Second) of Torts*, § 552 (1977). As we have recently stated in another context, "no person and no group should be given special privileges to negligently injure others

> without bearing the consequences. We do not favor special rules of tort nonliability . . .".

Thus, under the law of Pennsylvania, applying either intentional or negligent precepts, factual and legal bases exist to hold Travelers liable to CHS.

Neither the district court nor the court of appeals considered the foregoing law of Pennsylvania as it would apply to Travelers.

In this case, the issue is not one of poor judgment on the part of Mr. Reeves, or willful or wanton misconduct. There is overwhelming evidence to support findings that Mr. Reeves knew the nature of the services provided by CHS and that CHS served non-Medicare patients as well as Medicare patients. That fact was noted by this Court in footnote 4.[1] Mr. Reeves presumably knew that CHS could control the assignment of CETA employees' activities to non-Medicare patients and could isolate CETA employees from Medicare beneficiaries. He knew that services to non-Medicare patients would provide no basis for the Secretary to offset CHS charges for services for he knew CHS could maximize income through CETA grants only if such grants would not be offset against reimbursable costs. CHS raised the question for that reason and he supplied the factual "No Offset" answer.

Mr. Reeves knew that he was obligated by law to communicate CHS' request for an official answer and he

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[1]Presumably because CETA program participants provided services to some individuals not eligible for Medicare benefits, the aggregate amount of CETA reimbursements was substantially larger than the portion for which Medicare reimbursement was claimed. The total amount of reimbursement respondent received in CETA funds was $16,555, $53,952, and $81,118 in 1975, 1976 and 1977, respectively. ____ U.S. ____, 81 L. Ed. 2d at 50.

breached his duty. He did not communicate CHS' repeated question to the Secretary but, instead, without delay, repeatedly answered and assured CHS that the Secretary would not offset CETA grants. Audits approved the non-offsetting. Travelers was and is a multibillion dollar business for profit corporation, while CHS was and is a small non-profit corporation situated in rural western Pennsylvania with very limited resources which are factors that a jury can consider applying the law of Pennsylvania. CHS' operations were managed by one person who confessed his lack of knowledge of the subject matter to Travelers/Mr. Reeves with the request for an answer. In reliance on the statements made by Mr. Reeves, CHS continually directed CETA workers to provide services to Medicare beneficiaries, rather than direct them to serve only non-Medicare beneficiaries.

Only by reason of the Travelers' misrepresentations did the Secretary become entitled (by this Court's decision) to reclaim a portion of the benefit of the CETA grants against the cost of care for Medicare beneficiaries. CHS, to the extent of its liability to the Secretary, has been directly damaged by Travelers.

The issue of Travelers' liability for fraud, deceit and/or negligence could not have been raised before the Provider Reimbursement Review Board or in the original injunction proceedings and the district court erred in concluding that Travelers' acts were within its authority and in entering judgment for Travelers.

Before the court of appeals, the Secretary contended that even if Travelers is not immune from liability for acts outside its authority, the law of the case stemming from the decision of this Court with regard to the estoppel issue

precludes CHS from going further because this Court concluded that CHS did not justifiably rely on Mr. Reeves' representations; hence, Travelers cannot be independently liable to CHS for supplying misinformation.

The Secretary's argument has a certain simplistic logic, but the law of the case applies only to the decided issue of estoppel applying federal common law to a federal statute and federal rules and regulations and not to a state court common law action for damages wherein the law is different from federal law with regard to unjustified reliance as a defense. The argument also fails because this Court's conclusion with regard to CHS' conduct was not essential to the estoppel decision against the Secretary (Travelers' lack of authority was) and moreover, estoppel to deny a *contractual* agreement binding upon the Secretary and unjustified reliance as a defense to an independent contractor's tort liability for fraud, deceit, misrepresentation or negligence are distinct theories to be resolved applying the law of Pennsylvania, which this Court did not apply. Unjustified reliance is not a defense in all situations, particularly with regard to false statements.

Here, this Court simply did not have either the issue of Travelers' immunity or tort liability before it and the district court's holding that Travelers is immune from liability is based upon a conclusion rejected in toto by this Court. This Court's decision with regard to the estoppel issue was and is predicated on Travelers' lack of authority to interpret the regulation in response to CHS' requests. Otherwise, the Secretary would have been bound by her agent. This Court described Travelers as a mere conduit. This Court was guided by the principle that public funds should not be disbursed without authority (Travelers'/ Reeves' lack of authority to bind the Secretary) and was

unconcerned with any torts committed under state law for which Travelers would be liable as that issue was not before this Court.

Here, when Travelers is viewed as a mere conduit and its representations as outside of its authority, based upon the undisputed evidence, a finding by the district court that there is no evidence of willful or wanton misconduct on the part of Travelers is irrelevant or if relevant, is clearly erroneous in light of the record and moreover, is not a legal requirement for liability. Whether Travelers' actions constituted willful or wanton misconduct possibly may be argued by Travelers, but if so, the issue is for trial and not for summary judgment. However, this Court, in its decision, stated (at ____ U.S. ____, 81 L.Ed. at 50) as follows with regard to the duties of the intermediary:

> It is undisputed that the correct administrative practice required Travelers to refer respondent's inquiry to the Department of Health and Human Services for a definitive answer. However, Travelers did not do this until August 7, 1977 . . .

Thus, the breach of a legal duty to CHS is not open to dispute. CHS was given false information—not once, but five times. To conclude that the repeated failure to perform a statutory duty and to repeatedly give false information does not constitute reckless conduct is clearly erroneous. And, it was by reason of Travelers' conduct outside of its authority that CHS contended to the district court that CHS was entitled to judgment on its cross-motion.

At the oral argument before the court of appeals in August 1985, counsel for the Secretary and Travelers agreed to a suggestion that Travelers' Mr. Reeves' conduct

was at least negligent, an admission never examined or considered by the district court.

Petitioner contends that at the very least the district court's conclusion that Travelers was immune from liability to CHS must be vacated and the case returned to the district court for further proceedings consistent with this Court's prior decision that Travelers' acts were outside of its authority. In fact, summary judgment for CHS against Travelers would be proper on the record with the only issue remaining one of damages.

The denial of a day in court for CHS against Travelers under applicable laws of the Commonwealth of Pennsylvania is a denial of a constitutionally protected right. CHS' claim for damages against Travelers is not a claim against the United States. Travelers enjoys no privilege to injure CHS. Travelers' liability is to be determined under the applicable laws of the Commonwealth of Pennsylvania.

The position of CHS is supported by the decision in *Rochester Methodist Hospital v. The Travelers Insurance Company*, 728 F.2d 1006 (8th Cir. 1984). The decision was adverse to Travelers and Travelers did not seek relief from the decision.

In the *Rochester* case, the intermediary (Travelers) misrepresented to a hospital (hereinafter "First Hospital") that dormitory costs for its nursing education program were not reimbursable even though the intermediary was reimbursing another hospital (hereinafter "Second Hospital") in the same city for dormitory costs for the same nursing education program. The intermediary advised the First Hospital that an internal appeal would be fruitless and that pursuit for further relief would be futile. The First Hospital relied upon the intermediary's representations

and did not pursue an appeal on the issue and did not claim those costs on future cost reports. Subsequently, the First Hospital hired an accounting firm that was familiar with Travelers' reimbursement of the Second Hospital and who informed the First Hospital that Travelers had been reimbursing the Second Hospital for its dormitory costs in connection with the nursing education program. The First Hospital immediately sought reimbursement from Travelers for its dormitory costs for all prior years which resulted in an appeal by the First Hospital to the Provider Reimbursement Review Board ("PRRB"). There was an additional dispute involving retroactivity for prior years which prompted the litigation.

The initial complaint was filed against both Travelers and the Secretary alleging, in substance, that both defendants were estopped to deny the claims for reimbursement and that, in the alternative, Travelers had exceeded its authority in its dealings with the First Hospital. The Secretary, arguing that it was the real party in interest, moved to dismiss Travelers as a defendant. The district court denied the motion on the ground that if Travelers had exceeded its authority, the First Hospital's remedy might be against Travelers rather than the Secretary. The First Hospital's claim against the Secretary was subsequently transferred to the United States Claims Court and the action proceeded against only Travelers after the First Hospital amended its complaint alleging fraud, breach of implied warranty of authority and tortious misrepresentation of authority. In that action, the district court held that Travelers had committed the tort of fraud under the common law of Minnesota and entered judgment against Travelers. The Eighth Circuit affirmed the district court rejecting, among others, Travelers' sovereign immunity defense.

CONCLUSION

For the foregoing reasons, petitioner respectfully requests that its petition for certiorari be granted.

Respectfully submitted,

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APPENDIX A

United States Court of Appeals

FOR THE THIRD CIRCUIT

No. 82-5098

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., a non-profit corporation, ADA WERNER, an individual, FRANK E. WERNER, an individual, and SHIRLEY SORGER, an individual,

Plaintiffs-Appellants,

v.

JOSEPH A CALIFANO, JR., SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and THE TRAVELERS INSURANCE COMPANIES, a corporation,

Defendants-Appellees.

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., a non-profit corporation,

Plaintiff-Appellant,

v.

PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and THE TRAVELERS INSURANCE COMPANIES, a corporation,

Defendants-Appellees.

On Remand from the Supreme Court of the United States

Argued: August 5, 1985

Before: ALDISERT, *Chief Judge,* and HIGGINBOTHAM and MANSMANN, *Circuit Judges.*

JUDGMENT ORDER

After consideration of the Supreme Court's opinion, 104 S. Ct. 2218, and all contentions raised by appellants, it is ADJUDGED and ORDERED that the previous judgment of this court entered on January 19, 1983 be vacated, and that the judgment of the United States District Court for the Western District of Pennsylvania entered on November 16, 1981 (D.C. Civ. Nos. 80-56 and 78-74) be affirmed.

Each party to bear its own costs.

BY THE COURT,

/s/ A. LEON HIGGENBOTHAM
Circuit Judge

ATTEST:
/s/ SALLY MRVOS
SALLY MRVOS, *Clerk*
DATED: August 7, 1985

APPENDIX B

United States Court of Appeals

FOR THE THIRD CIRCUIT

No. 82-5098

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., etc.,

Appellants

v.

JOSEPH A. CALIFANO, JR., ET AL.,

SUR PETITION FOR REHEARING

Before: ALDISERT, *Chief Judge*, SEITZ, ADAMS, GIBBONS, HUNTER, WEIS, GARTH, HIGGINBOTHAM, SLOVITER, BECKER, STAPLETON, MANSMANN *Circuit Judges*.

The petition for rehearing filed by Community Health Services of Crawford County, Inc., Ada Werner, Frank E. Werner and Shirley Sorger, Appellants in the above-entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court in banc, the petition for REHEARING IS DENIED.

BY THE COURT,

/s/ A. LEON HIGGENBOTHAM
Circuit Judge

Dated: September 3, 1985

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 80-56 Erie

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., A NON-PROFIT CORPORATION, *PLAINTIFF*

v.

PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE TRAVELERS INSURANCE COMPANIES, A CORPORATION, *DEFENDANTS.*

MEMORANDUM OPINION

On April 10, 1980, Community Health Services (CHS), a nonprofit corporation existing under the laws of Pennsylvania, filed a complaint under § 1878(f)(1) of the Social Security Act (the Act), 42 U.S.C. § 1395oo(f)(1), to review a final decision of the Secretary of the Department of Health and Human Services (the Secretary) disallowing certain claims for Medicare reimbursement for the years 1976 and 1977.[1] This decision was rendered by the Department's Provider Reimbursement Review Board (PRRB) on March 12, 1980 following a formal hearing.

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[1]On June 3, 1980 this action was consolidated with C.A. No. 78-74 Erie, a case filed on July 12, 1978 based on the same facts. In that case, the court denied motions to dismiss and for summary judgment pending further discovery and agency action. By stipulation of counsel, the Secretary agreed to cease recoupment of the overpayment and refund all monies already recouped from plaintiff pending resolution of this action.

Defendants moved for summary judgment on August 25, 1980 and plaintiff responded with a similar motion on September 17, 1980. The matter was argued orally before the court in Erie on October 30, 1980 and the matter is now ready for disposition.

BACKGROUND

Without delving into great detail concerning the statutory scheme for Medicare funds, some explanation of the parties and the plan is necessary. Plaintiff is a "home health agency" as defined in § 1861(o) of the Act, 42 U.S.C. § 1395x(o), and is a "provider" of home health services within the meaning of § 1851(a), 42 U.S.C. § 1395x(u). Defendant Harris is the federal officer responsbile for the administration of the Social Security Act. Defendant, Travelers, acted as a fiscal "intermediary" under § 1816, 42 U.S.C. § 1395h and, as such, acted as an agent of the government in making payments to providers of home health services under Parts A and B of Title XVIII of the Act. The primary duty of the intermediary is the processing of claims and payment of funds to the provider.

Beginning in 1966, CHS entered into an agreement with the Secretary to provide home health services to eligible individuals under the Act and the Secretary agreed to reimburse CHS the reasonable cost of such services. Since that time, CHS has been dealing with the Secretary's fiscal intermediary, providing it with all cost related information required. In April of 1975, CHS entered into a series of contracts with the Mercer County Consortium Services, Inc., by which CHS was to employ participants in a program under the Comprehensive Employment and Training

Act of 1963 (CETA), 29 U.S.C. § 801 *et seq.* CETA established programs designed to provide job training opportunities for unemployed individuals by allocating funds to state or local governments which, in turn, arrange manpower programs. Under the terms of the CETA grants, CHS was to employ participants in the program furnished by the regional CETA administration and was reimbursed by CETA for the salaries and fringe benefits paid to those employees. The purpose of the CETA program, as stated in the contract signed by CHS, is "to provide work training and experience for the purpose of enhancing the future employability of participants in obtaining a planned occupational goal."

The administrator of CHS contacted a representative of the intermediary to discuss the treatment of the CETA grants for purposes of Medicare reimbursements. While there was no official government policy on the treatment of CETA funds, CHS was informed by the medicare manager of the intermediary, Michael J. Reeves, that the CETA funds qualified as "seed money" pursuant to § 612.2 of the Provider Reimbursement Manual (HIM-15-1) and that the actual cash value of CETA employees need not be offset against reimbursable costs. CHS prepared its cost reports on this basis and these reports were approved by the intermediary for the years 1975, 1976 and 1977. In effect, CHS was being paid twice by the government for the salaries of CETA participants—the Secretary was charged for the salaries of these employees as part of the reasonable cost of providing medical care while CETA was paying for these salaries from government grants. It was not until August 4, 1977 that the intermediary requested a formal opinion from superiors and learned that CETA funds were to be offset against costs. Plaintiff was advised of this by letter

dated October 7, 1977 and by personal instructions from Mr. Reeves on November 9, 1977.

Pursuant to the statutory procedure, the Secretary reopened plaintiff's cost reports for 1975, 1976 and 1977 to make adjustments for the CETA funds which should have been offset against costs. Notices of Program Reimbursements were sent to plaintiff. CHS than appealed this determination to the Provider Reimbursement Review Board (PRRB) and was provided with a trial-type hearing on January 22, 1980. The PRRB denied plaintiff's appeal on March 12, 1980 and this appeal followed.

Judical review of the PRRB decision is limited to that set out in § 10(e) of the Administrative Procedure Act (APA) 5 U.S.C. § 706(2)(E). 42 U.S.C. § 1395oo(f)(1). That section reads, in pertinent part:

> [t]o the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The review court shall— . . .
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be— . . .
>
> (E) unsupported by substantial evidence in a case subject to review on the record of an agency hearing.

In making this determination, the court shall review the whole record, or those parts cited by the parties. Questions of fact are reviewed on the substantial evidence standard while, in deciding questions of law, the court must determine whether the correct legal standard was applied.

I. Did the PRRB Err As A Matter of Law In Holding That CETA Funds Do Not Qualify For The "Seed Money" Exceptions?

Plaintiff argues that the PRRB erred as a matter of law in concluding that the CETA funds which were used by CHS to pay its CETA employees were not "seed money" and therefore, should have been deducted from operating costs in computing reimbursable costs. We have carefully reviewed the decision of PRRB on this point and conclude that there was no error in excluding CETA funds from the "seed money" exception.

The plain language of the relevant statutes under the Act are clearly supportive of the PRRB's determination. At 42 C.F.R. § 405.423(a), the regulations provide that grants to providers shall, for the purposes of reimbursement, be treated as follows:

> Unrestricted grants, gifts and income from endowments should be deducted from operating costs in computing reimbursable cost. Grants, gifts, and endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs.

The term "restricted grant" is defined at 42 C.F.R. § 405.423(b)(2) as:

> . . . funds, cash or otherwise, which must be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the provider.

The CETA funds at issue in this case cannot be characterized as "unrestricted funds." The agreement under which plaintiff receives the CETA funds specifically states that

"Grantor agrees that for the duration of the term of this Agreement, Grantor will (b) Reimburse Grantee for actual costs incurred in Grantee's payment of compensation and fringe benefits to participants provided by Grantor. . . . (Tr. 424) Certain restricted grants, however, qualify for the "seed money" exception which is found in the Department's Provider Reimbursement Manual, HIM-15, Part I, § 612, entitled "Public Health Service Grants." A Public Health Service Grant is one which is authorized under the Public Health Service Act, 42 U.S.C. § 201 *et seq.* The exception for "seed money" is as follows:

> [G]rants designated for the development of new health care agencies or for expansion of services of established agencies are generally referred to as "seed money" grants. "Seed money" grants are not deducted from costs in computing allowable costs. These grants are usually made to cover specific operating costs or groups of costs for services for a stated period of time.

Our attention is particularly drawn to the words "designated for the development of new health care agencies." Clearly CETA funds were not specifically so designated and no tortured construction of the statute could bring the CETA grants within the "seed money" exception.

Plaintiff argues that the CETA funds were used to employ additional personnel at CHS and therefore resulted in an expansion of health care service at the institution. It contends, therefore, that since the net effect of the utilization of the CETA moeny was to benefit and expand a health care agency, the CETA funds should qualify under the "seed money" exception. The PRRB adequately addressed this argument and concluded that this is insufficient to bring CETA funds within the exception. (PRRB

decision at 5) We therefore find that the PRRB did not err as a matter of law in reaching this determination.

II. Should The Government Be Estopped To Recoup These Overpayments?

Plaintiff argues that the government should be estopped from recovering the overpayment in this case since from the spring of 1975 through August of 1977 it had been assured by a representative of the intermediary that CETA funds would not be offset for the purposes of Medicare reimbursement. Subsequently, on September 20, 1977, the Medicare Bureau informed the intermediary, who in turn informed CHS, that CETA funds are restricted grants and not within the "seed money" exception. Plaintiff alleges that it relied to its detriment on this advice and spent the money represented by the additional Medicare reimbursement on expanding its services. According to plaintiff, these facts establish deterimental reliance by the provider on misinformation given it by the intermediary.

It is now clearly established that estoppel may lie against the government in certain limited circumstances. *Brown* v. *Richardson*, 395 F. Supp. 185 (W.D. Pa. 1975). These circumstances were discussed thoroughly in *Brown* v. *Richardson* and the court held that the government could not be estopped to deny benefits as the result of a statement made in a Medicare handbook. In reaching this conclusion, the court cited the Supreme Court decision in *Utah Power and Light Co.* v. *United States*, 243 U.S. 389 (1917) which held that:

> [T]he United States is neither bound nor estopped by acts of its officers or agents in entering into an arrangement or agreement to do or cause to be done what the law does not sanction or permit. 395 F. Supp. at 189.

The court went on to note that:

> [B]y operation of law, parties dealing with the government are charged with knowledge of, and are bound by, statute and lawfully promulgated regulations, and reliance upon incorrect information received from government agent or employee cannot alter the terms of a statute regardless of the economic hardship which may result. *Id.* at 190.

In this case, the regulations dealing with Medicare reimbursement clearly provide that only those grants "designated" for the expansion of health care services would qualify under the "seed money" exception. The fact that Mr. Reeves erroneously advised CHS that CETA funds qualified for the exception cannot alter the principles upon which the Medicare Act is based. Even if estoppel would properly lie in this case, the plaintiff's unjustified reliance upon the advice of the intermediary would preclude application of the doctrine. As stated in *Brown* v. *Richardson*, "an estoppel arises where one party by words or action makes a false representation of fact and the other party reasonably relies on that representation and is prejudiced thereby." *Id.* at 191. Elaborating on the reasonableness of reliance, the court stated:

> One who claims the benefits of an estoppel on the ground that he has been misled by the misrepresentations of another must not have been misled by his own lack of reasonable care and circumspection. A lack of diligence by a party claiming an estoppel is generally fatal. If the party conducts himself with careless indifference to the means of information reasonably at hand or ignores highly suspicious circumstance, he may not invoke the doctrine of estoppel.

The Medicare regulations allow the intermediary to reopen the cost reports up to three years after they have been approved. This, CHS relied at its own risk in accepting the intermediary's advice since plaintiff was on notice that all such reports were subject to review. Moreover, the fact that CHS was being reimbursed twice for the same expense should have been a red flag that its windfall was not supportable under the Act.

III. Is Defendants Attempt to Recoup The Overpayments Contrary to Law?

Plaintiff argues that if indeed it did receive an overpayment due to the treatment accorded to the CETA grants, defendants acted contrary to law by attempting to recoup those overpayments since it was without fault. This argument is premised on 42 U.S.C. § 1395gg and 42 C.F.R. § 405.355 which provide for waiver of adjustments in certain circumstances. Congress provided in the Act at 42 U.S.C. § 1395gg(b) and (c):

> (b) Where—
>
> (1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines . . .
>
> (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount. . . .
>
> proper adjustments shall be made . . . by decreasing subsequent payments— . . .
>
> (c) There shall be no adjustments as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made . . . with respect to an individual who is without

> fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience. . . .

Defendants contend that this section of the Act does not apply in a case such as this, that there is no provision in the Act giving the Secretary authority to waive overpayments to the provider and therefore under 42 U.S.C. § 1395g the Secretary is obligated to recover the overpayments.

Based upon a fair reading of these statutory provisions and the detailed consideration given to them in *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F.2d 329 (5th Cir. 1975) *cert. denied*, 425 U.S. 935 (1976) (hereinafter *Mt. Sinai)*, we are unwilling to determine that the Secretary acted contrary to law by seeking to recover the overpayments in this situation.

Section 1395gg deals with preconditions to recovery against individual beneficiaries and provides that in cases of overpayment in noncovered or excluded services where the recoupment could not be recovered from the provider or where the provider was without fault, the Department will not seek recovery from the provider but will determine whether recovery from the beneficiaries is permissible. This implied waiver only exists where, in the absence of recovery from the provider, the overpayment could, if not prohibited by other statutory provisions, be recouped from the beneficiary. This section authorizes the Secretary to recoup overpayments from beneficiary's old-age benefits, but only where "the excess over the correct amount

could not be recouped from the provider. *Mt. Sinai,* 517 F.2d at 336.

In *Mt. Sinai,* the provider contested the Secretary's attempt to recoup payment for medical services and supplies to beneficiaries which later turned out to be medically unnecessaary. After an in-depth statutory analysis, the Fifth Circuit Court of Appeals distinguished overpayment arising from noncovered or excluded services from those arising from erroneous "reasonable cost" determinations and held that § 1395gg applied only to overpayments arising from noncovered or excluded services. *Id.* 340-342. *Mt. Sinai* does suggest in a footnote that in cases of overpayment based on noncovered or excluded services, the lack of fault on the part of the provider would be a defense to recoupment, but does not deal with reasonable costs. *Id.* at 33.

While there is no explicit authority in the statute to waive recoupment from the provider, we find it difficult to believe that the Secretary is wholly without power to do so where it appears that individual recipients would suffer or the purpose of the Act would be frustrated. In addition, we note that in the PRRB Hearing Manual at § 52(g), the Board is denied jurisdiction over "the waiver of an overpayment to a provider or the manner of repayment." The clear implication of this section is that such waivers are permitted should the Secretary determine it appropriate. However the decision of the Secretary not to waive recovery in this case is a discretionary one, presumably based upon all the relevant facts and we are not able to find that his discretion was abused in this case.

IV. Is Plaintiff Entitled To A Pre-Recoupment Hearing?

Plaintiff argues that the denial of its waiver request without an agency hearing constitutes a violation of its right to due process under the Fifth Amendment of the United States Constitution. The PRRB did not address the waiver issue since it is without jurisdiction to do so under § 1150.52(g) of the PRRB Hearing Manual.

As we have just discussed, there is no specific statutory provision requiring waiver by the government in favor of the provider where there have been overpayments as to the reasonable costs of services. Plaintiff does not base its assertion on any statutory right to waiver, but rather relies on a traditional due process argument that its statutory entitlement to reimbursement for the reasonable cost of services rendered to Medicare beneficiaries creates a property interest which is entitled to procedural due process protection before termination.

In the prior law suit before this court concerning the same overpayments, the Secretary agreed to cease recoupment of the overpayment and refund to plaintiff all monies already recouped. Recoupment was stayed pending resolution of the dispute, and consequently, no portion of the overpayment has been recovered by the Medicare program. In the interim, an indepth hearing was held before the PRRB to determine whether the CETA funds qualified as "seed money" and that the adjustments made were proper. Presently, this court is entertaining plaintiff's arguments on the merits of that decision and the constitutionality of the hearing. Now the plaintiff asks us to find that a pre-recoupment hearing on the question of waiver is constitutionally required. We have already considered the decision of the Secretary not to waive recoupment and

have decided that she did not abuse her discretion in reaching this decision. All of this had been afforded plaintiff before any monies have actually been recouped. We therefore find no case or controversy which would enable us to reach the more general question of whether a pre-recoupment hearing on the issue of waiver should be required in all cases.

V. Is Traveler's Independently Liable to Plaintiff?

Plaintiff asserts that Travelers was acting ultra vires by deliberately and consciously misadvising CHS on the cost accounting treatment of CETA funds when it knew that no government policy had been set forth and knew that its advice could not substitute for that of the Secretary. Therefore, plaintiff believes that Travelers should be held independently liable to it for the overpayment.

It is well established that a mere mistake of judgment does not constitute activity outside a federal official's authority so as to make him or her personally liable for damages. *Butz* v. *Economu*, 438 U.S. 478 (1978). As an agent of the Secretary pursuant to § 1816 of the Act, 42 U.S.C. § 1395h, Travelers and its representatives enjoy the same immunity from damage suits as a federal official. *Matrana* v. *Travelers Insurance Company*, 563 F.2d 677 (5h Cir. 1977).

The duties of the intermediary are outlined in the Act at 42 U.S.C. § 1395h(a) and in the agreement entered into between Travelers and CHS. Included among these duties are the responsibility for provide consultative services to the institutions, to serve as a channel of communication to the Secretary and to review and settle provider cost reports. Mistakes in the treatment of cost items were

expected and provided for in the regulations. 42 U.S.C. § 405.1885(b) provides:

> (b). A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

In this case there is no question but that Michael Reeves gave incorrect advice to the provider and approved cost reports reflecting that erroneous advice. But there is no evidence of willful or wanton misconduct on the part of Mr. Reeves. It is inconceivable that the government could have an established policy for each and every possible grant received by a provider and it is expected that the intermediary will give its opinion on unexpected questions that arise. It is also expected that those opinions will not always coincide with the position of the Secretary. The regulations make it clear that it is the statutes themselves and the opinion of the Secretary which is controlling. It does appear that Mr. Reeves exercised poor judgment by waiting so long before checking with his superiors on the correct application of CETA funds. However, as earlier stated, mistakes of judgment do not constitute activity outside the federal official's authority. We find no basis for holding Travelers independently liable to plaintiffs.

VI. Did Defendant's Retroactively Apply a Policy Change Without Complying with the APA?

Plaintiff interpretes [sic] the Secretary's instructions to offset CETA grants against the reasonable costs reimbursed

by Medicare as a change in policy requiring the procedure set out in the APA for rulemaking. Further, plaintiff argues that such a change in policy cannot be applied retroactively.

As has been stated earlier, the intermediary's oral advice that the provider's CETA grants constituted "seed money" cannot alter the controlling statutory law. The intermediary was mistaken in its interpretation of the law and its correction of this mistake after seeking and receiving guidance from the Secretary did not constitute a substantive change in the Secretary's policy. Since we have determined that there never was an official "policy" with respect to the treatment of CETA funds, there cannot have been a policy change.

VII. Did PRRB Improperly Exclude Evidence Offered By Plaintiff?

Plaintiff alleges that the PRRB abused its discretion by preventing it from introducing evidence showing discriminatory application of governmental policy by denying its request to subpoena or depose a particular witness and by precluding it from showing Travelers' arbitrary application of the policy with respect to CETA grants.

Under 5 U.S.C. § 556(c), employees presiding at agency hearings are to issue subpoenas authorized by law, rule on offers of proof and receive relevant evidence, have depositions taken when the ends of justice would be served, and regulate the course of the hearing. Further in 5 U.S.C. § 556(d), the agency is authorized to provide for the exclusion of irrelevant, immaterial or unduly repetitious evidence. The record indicates that after an offer of proof and extensive argument, the chairman of the PRRB ruled that the testimony of the witness who refused to appear

voluntarily, was not "germane to the basic question in this case as to whether or not this Provider was treated in accordance with the regulations and fairly and given due process and so it will not be accepted." (Tr., 160).

The hearing examiner has wide latitude as to all phases of conduct of the administrative hearing. *Cella* v. *United States,* 208 F.2d 783 (7th Cir. 1953), *cert. denied,* 347 U.S. 1016, and the definition of the scope of the proceeding raises questions which particularly call for agency judgment. *Ashbacker Radio Corp.* v. *Federal Communications Commission,* 326 U.S. 327 (1945). We have reviewed the colloquy leading up to the evidentiary ruling and studied the issues before the Board, and cannot see that the exclusion of this evidence was in any way an abuse of the PRRB's discretion.

For all the above reasons, we find the merits of this undisputed controversy to lie with the defendants and therefore grant their motion for summary judgment. Of necessity, plaintiff's motion must be denied. An appropriate order will be entered.

/s/ WILLIAM W. KNOX
U.S. District Judge

December 29, 1980

cc: Counsel of record.

APPENDIX D

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

80-D12

CASE NO. 78-215

PROVIDER—COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC.
MEADVILLE, PENNSYLVANIA
PROVIDER No. 39-7041

v.

INTERMEDIARY—THE TRAVELERS INSURANCE COMPANY

Date of Hearing—January 22, 1980
Cost Reporting Period Ending—October 31, 1975, 1976 and 1977

ISSUE

Whether or not Comprehensive Employment and Training Act Funds (CETA) qualify as unrestricted funds pursuant to 42 CFR 405.423?

SUMMARY OF FACTS

Community Health Services of Crawford County, Inc., is a nonprofit home health agency. The agency performed 5,210, 7,757, and 8,246 home health visits for the cost reporting periods respectively ending October 31, 1975, 1976 and 1977. Cost reports for the aforementioned periods were filed with the Provider's fiscal intermediary, Travelers Insurance Company.

During the periods in question, the Provider included in its reimbursable cost the salaries and fringe benefits of

CETA employees. Pursuant to the CETA participatory agreements, the Provider was reimbursed for the salary and fringe benefits of its CETA employees. Accordingly, the Provider received the following reimbursement for its CETA employees:

1975	$16,555
1975	$53,952
1977	$81,118

In filing its cost reports for the periods ending 1975 and 1976, the Provider included in allowable costs the salary and fringe benefits of CETA employees without a corresponding offset for the CETA funds received. The Intermediary accepted the Provider's treatment of the CETA funds received. Notices of Program Reimbursement were issued the Provider on April 19, 1976 and April 12, 1977, for the cost reporting periods respectively ending October 31, 1975 and 1976. Throughout these periods, it was the opinion of the Intermediary that CETA funds qualified as "seed money" pursuant to Section 612.2 of the Provider Reimbursement Manual (HIM-15-1). On August 4, 1977, the Intermediary sought advice from the Philadelphia Regional Office of the Health Care Financing Administration (HCFA) concerning the treatment of CETA funds. In response to this inquiry, the Regional Office advised Travelers on September 20, 1977, of the following:

> "Where the employer includes these persons on its payroll, the amounts reimbursed by CETA for wages and fringes should be offset against the cost." (Intermediary's Position Paper, Exhibit 5)

Travelers, therefore, notified the Provider on October 7, 1977, that where CETA participant's wages and fringes are included in the expenses of a provider, applicable CETA

grants must be used to offset expenses for Medicare cost reimbursement purposes. Subsequently, the Provider filed its cost report for the period ending October 31, 1977, on February 2, 1978. Once again, the Provider did not give recognition to offsetting salaries and fringe benefits by CETA Funds. Hence acting on the advice of HCFA's Regional Office, Travelers revised the Provider's 1975 and 1976 settlements to recognize such an offset. Revised Notices of Program Reimbursement were mailed to the Provider on May 24, 1978 and June 5, 1978, for the cost years respectively ending October 31, 1975 and 1976. Likewise, as a result of a desk review of the Provider's 1977 cost report, a similar offset was made for CETA funds. A Notice of Program Reimbursement for 1977 was mailed to the Provider on June 26, 1978. The Provider takes exceptions to these adjustments and has filed a timely appeal before the Provider Reimbursement Review Board.

The Provider submits that the offsetting of CETA funds against salaries and fringe benefits is improper. The Provider contends that CETA funds qualify as "seed money" pursuant to Section 612.2, HIM-15-1. In the instant case, the Provider alleges that the receipt of CETA funds enabled it to expand its scope of services.

> "*Seed-Money Grants.*—Grants designated for the development of new health care agencies or for the expansion of services of established agencies are generally referred to as 'seed money' grants. 'Seed money' grants are not deducted from costs in computing allowable costs" (Section 612.2, HIM-15-1)

The CETA funds, argues the Provider, are to supplement its funds not supplant its funds.

> "CETA funds will, to the extent practicable, be used to supplement, rather than supplant the level of funds

> that would otherwise be available for the planning and administration of programs under the eligible applicant's grants [Section 703(ii)]." (Assurances and Certification attachment to Memorandum of Agreement, Provider's Position Paper, Exhibit J)

The Assurances and Certifications of the CETA Grant further provide:

> "Jobs are in addition to those that would be funded by the sponsor in the absence of assistance under the Act Section 205(c)(24)."

Accordingly, the Provider asserts that CETA grants should be accorded the treatment of "seed money."

Further, the Provider argues that the Intermediary is estopped from raising the issue of offset. The estoppal argument is predicated on the fact that the Intermediary for nearly two years advised the Provider that salaries and fringe benefits need not be offset by CETA funds.

To the contrary, the Intermediary asserts that CETA funds do not qualify as "seed money." The Congressional intent of CETA funding is to provide jobs or training for the unemployed. Congress did not view CETA funding as a mechanism to expand health care services. Further, the Intermediary argues that pursuant to 42 CFR 405.1885(b), it is required to revise a provider's settlement where an earlier determination is contrary to applicable general instructions. Hence the Intermediary is not estopped from revising prior cost settlements.

CITATION OF APPLICABLE LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

A. Regulations—42 CFR 405, Regulations No. 5, Subpart D

Section 405.423 Grants, gifts, and income from endowments.

B. Program Instructions—Provider Reimbursement Manual, Part 1 (HIM-15-1)

Section 612.2 Seed-Money Grants

CONCLUSIONS AND FINDINGS

The Provider Reimbursement Review Board, after consideration of the facts, the parties' contentions, and evidence presented concludes and finds that salaries and fringe benefits paid to CETA employees must be offset by the receipt of CETA funds for the period ending October 31, 1977.

The Regulations at 42 CFR 405.423 very implicitly state that donor-restricted funds which are designated for paying certain hospital operating expenses should apply and serve to reduce these costs or group of costs. In the instant case, the CETA grant was restricted to specifically pay the salaries and fringe benefits of the CETA employees of the Provider.

> "5. Grantor agrees that for the duration of the term of this Agreement, Grantor will:
>
> . . .

b) Reimburse Grantee for actual costs incurred in Grantee's payment of compensation and fringe benefits to participants provided by Grantor . . . "

(Memorandum of Agreement, Intermediary Position Paper, Exhibit 1)

Further, the Board finds the purpose of "seed money" as defined by Section 612.2, HIM-15-1 and a CETA grant is clearly distinguishable. "Seed money" as defined by the Manual is a grant designated for the development of new health care agencies or for the expansion of services of established agencies. The purpose of the Comprehensive Employment and Training Act of 1973 is "to provide job training and employment opportunities for economically disadvantaged, unemployed, and under employed persons, and to assure that training and other services lead to maximum employment opportunites." (29 USC 801—Congressional statement of purposes) Although the residual effect of CETA funding in the instant case may have contributed toward an expansion of services, the purpose of CETA funding is clearly to assure opportunities for employment and training to unemployed and under employed persons. (House Report No. 93-659) The Board finds that greater weight must be accorded the purpose of a donor restricted grant rather than an alleged residual effect in determining whether a grant qualifies as "seed money."

Further, the Board finds that the adjustments proposed to the 1975 and 1976 cost reports are improper. Pursuant to 42 CFR 405.1885, a determination of an intermediary may be reopened within three years of the date of a Notice of Program Reimbursement. The Regulations continue to state:

"Section 405.1887 Notice of Reopening

(a) All parties to any reopening described above shall be given written notice of the reopening. When such reopening results in any revision in the prior decision, notice of said revision or revisions will be mailed to the parties with a complete explanation of the basis for the revision or revisions . . ."

These principles are also reiterated in Part A Intermediary Manual, Part 2, Audits Reimbursement Program Administration (HIM-13-2). Section 2632, HIM-13-2, directs the intermediary to give written notice to the provider of a reopening. In reviewing the record for the cost reporting periods ending October 31, 1975 and 1976, no such notice was given the Provider. In addition, the Board finds that the Intermediary is barred by statute from giving notice of a reopening for the 1975 cost reporting period. However, the defect for the 1976 cost reporting period may be corrected. The statute of limitation for the latter year extends to April 14, 1980. Should the Intermediary render a timely notice of reopening to the Provider for the cost reporting period ending October 31, 1976, the decision of this Board for the cost reporting period ending October 31, 1977, will be equally applicable to the 1976 cost reporting period.

Finally, the Board would like to acknowledge the Provider's argument concerning the role of the fiscal intermediary. The Regulations succinctly state that "an important role of the fiscal intermediary, in addition to claims processing and payment and other assigned responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure equitable payment under the program" [42 CFR 405.401(e)]. However, it should be emphasized that

the role of the intermediary is not to establish the principles of reimbursement. This is the responsibility of the Secretary. Although the Provider acted in good faith in not offsetting salaries and fringe benefits by CETA funds, advice by the Intermediary cannot be a substitute for the opinion of the Secretary.

DECISION

The Intermediary is sustained for the cost reporting period ending October 31, 1977. CETA funds are not to be treated as "seed money." The adjustments of the Intermediary are reversed for the periods ending October 31, 1975 and October 31, 1976, inasmuch as proper notices of reopening were not sent to the Provider.

In the event that the Intermediary renders a timely notice or reopening to the Provider for the cost reporting period ending October 31, 1976, the decision of this Board for the cost reporting period ending October 31, 1977, will be equally applicable to the 1976 cost reporting period.

Board Members Participating

Thomas M. Tierney
Carolyn B. Lewis
H. Joseph Curl

FOR THE BOARD

/s/ THOMAS M. TIERNEY
Thomas M. Tierney
Chairman

March 12, 1980

Supreme Court, U.S.
FILED
DEC 6 [illegible]
JOSEPH F. SPANIOL, JR.
CLERK

(2)

No. 85-613

In the Supreme Court of the United States

OCTOBER TERM, 1985

COMMUNITY HEALTH SERVICES OF CRAWFORD COUNTY, INC., PETITIONER

v.

THE TRAVELERS INSURANCE COMPANIES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

MEMORANDUM FOR THE RESPONDENTS IN OPPOSITION

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Petitioner contends that respondent The Travelers Insurance Companies may be held liable for misrepresentations made in the course of its duties as a Medicare fiscal intermediary notwithstanding this Court's holding in *Heckler* v. *Community Health Services*, No. 83-56 (May 21, 1984), that petitioner could not reasonably have relied on those misrepresentations.

1. Petitioner Community Health Services of Crawford County, Inc. (CHS), a provider of home health care services, has participated in the Medicare program since 1966. Its Medicare payments are made through a fiscal intermediary, respondent The Travelers Insurance Companies (Travelers). Travelers erroneously advised petitioner between 1975 and 1977 that certain funds received by petitioner under the Comprehensive Employment and Training Act of 1973 (CETA), 29 U.S.C. (1976 ed. & Supp. V) 801 *et seq.*, were reimbursable under Medicare as

well, thus allowing petitioner the windfall of "being reimbursed twice for the same expense." Pet. App. 12a. When the Department of Health and Human Services became aware of petitioner's accounting practices in 1977, it advised Travelers that the CETA funds were not reimbursable. Pursuant to the Social Security Act and applicable regulations, Travelers reopened petitioner's earlier cost determinations in order to make the necessary retroactive adjustments and to recoup on behalf of the government overpayments of $71,480. *Id.* at 5a-7a; *Heckler* v. *Community Health Services*, No. 83-56 (May 21, 1984), slip op. 1-5.

Following an unsuccessful administrative challenge, petitioner commenced this action against Travelers and the Secretary of Health and Human Services in the United States District Court for the Western District of Pennsylvania, contending, inter alia, that the Secretary was estopped on the basis of Travelers' oral misstatements from recouping the overpayments and that Travelers was independently liable to it for whatever repayments by petitioner to the government were required. The district court granted summary judgment in favor of Travelers and the Secretary in an unreported memorandum opinion. Pet. App. 4a-19a. The district court concluded that the Secretary could not be estopped because petitioner could not reasonably have relied on Travelers' advice as final. *Id.* at 10a-12a. The district court also concluded that Travelers was entitled to official immunity from liability under Pennsylvania tort law for erroneous statements made in the course of its duties as a fiscal intermediary. *Id.* at 16a-17a.

The court of appeals reversed on the ground that the Secretary was estopped from recouping the overpayments. 698 F.2d 615 (1983). This Court granted the Secretary's petition for a writ of certiorari and reversed the judgment of the court of appeals. *Heckler* v. *Community Health*

Services, supra. The Court held that CHS could not estop the Secretary because Travelers' advice was not "given under circumstances that should have induced [CHS's] reliance." Slip op. 12. The Court reasoned that CHS should have known that final resolution of the reimbursement question rested with the Secretary and that Travelers' advice therefore could not be binding. *Id.* at 12-14.

On remand from this Court, the court of appeals entered an unpublished judgment order affirming the district court's grant of summary judgment in favor of the Secretary and Travelers. Pet. App. 1a-2a.

2. The order of the court of appeals, which, as petitioner recognizes (Pet. 5), "did not make a statement of the law," is manifestly correct and fully supported by state tort law. Further review is unwarranted.

Petitioner's tort action against Travelers could only succeed under Pennsylvania law if petitioner's reliance on Travelers' misstatements was reasonable. See Restatement (Second) of Torts §§ 537, 552 (1977); *Eisenberg* v. *Gagnon*, 766 F.2d 770, 778-779 (3d Cir. 1985); *Rempel* v. *Nationwide Life Ins. Co.*, 471 Pa. 404, 408, 370 A.2d 366, 367-368 (1977); *Mill-Mar, Inc.* v. *Stratham*, 278 Pa. Super. 296, 299, 420 A.2d 548, 550, appeal dismissed, 499 Pa. 219, 452 A.2d 1017 (1982). *Bowman* v. *Home Life Ins. Co.*, 260 F.2d 521 (3d Cir. 1958), on which petitioner relies (Pet. 12), is not to the contrary. See 260 F.2d at 523 ("once a party should be on notice, i.e., once his reliance is unreasonable, he acts at his own risk"). This Court has already held that petitioner's reliance was unreasonable. There is no need to revisit the question.[1]

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[1] The Court made clear in *Community Health Services* that CHS could not satisfy the requirements for estopping a private party. Slip op. 14. There is accordingly no reason to conclude that CHS's reliance might have been reasonable for purposes of its action against Travelers even though it was unreasonable for purposes of defending against recoupment by the Secretary.

In any event, Travelers is entitled to official immunity for state law torts resulting from discretionary acts taken within the scope of its duties as a fiscal intermediary under Medicare. See *Bushman* v. *Seiler*, 755 F.2d 653 (8th Cir. 1985); see also *Anderson* v. *Occidental Life Ins. Co.*, 727 F.2d 855 (9th Cir. 1984); *Matranga* v. *Travelers Ins. Co.*, 563 F.2d 677 (5th Cir. 1977). See generally *Harlow* v. *Fitzgerald*, 457 U.S. 800, 807-808 (1982); *Butz* v. *Economou*, 438 U.S. 478, 495 (1978); *Barr* v. *Matteo*, 360 U.S. 564, 570-572 (1959) (plurality opinion).[2] In accordance with congressional intent, the Secretary's regulations specify that the Administrator of the Health Care Financing Administration is the "real party in interest in any litigation involving the administration of the [Medicare] program." 42 C.F.R. 421.5(b); see S. Rep. 89-404, 89th Cong., 1st Sess. Pt. I, at 54 (1965); 42 U.S.C. 1395h(i)(2); *United States* v. *Erika, Inc.*, 456 U.S. 201, 205-206 n.4 (1982).[3] It would lead to intolerable burdens on the Medicare program if intermediaries were liable for their misstatements to providers. Administrative and judicial review of reimbursement decisions is available, and petitioner took full advantage of those mechanisms. Congress surely did not intend to permit providers yet another bite at the apple through state law tort actions against fiscal intermediaries.

Petitioner argues (Pet. 7-8, 11-12) that official immunity is unavailable because Travelers was acting outside the scope of its authority. Petitioner confuses two distinct inquiries. It is true, as the Court held in *Community Health*

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[2] Petitioner's reliance (Pet. 18-19) on *Rochester Methodist Hosp.* v. *Travelers Ins. Co.*, 728 F.2d 1006, 1012-1016 (8th Cir. 1984), is unavailing. There, the court of appeals held only that a fiscal intermediary is not entitled to sovereign immunity. However, the Eighth Circuit later held in *Bushman* v. *Seiler*, *supra*, that intermediaries are entitled to official immunity, the doctrine here at issue.

[3] Accordingly, the government has represented Travelers throughout this litigation.

Services, that Travelers did not have authority to bind the Secretary. Slip op. 12-13 & n.21. The question for official immunity purposes, however, is not whether the agent's actions are binding on the government but whether they were "taken within the outer perimeter of [its] line of duty." *Barr* v. *Matteo*, 360 U.S. at 575 (plurality opinion). In requesting advice, petitioner dealt with Travelers in Travelers' official capacity as a fiscal intermediary. And Travelers' advice, though erroneous, plainly was within the scope of its duties as a fiscal intermediary to "provide consultative services" to health care providers and to "serve as a channel of communication." Pet. App. 16a. As the district court noted, "it is expected that the intermediary will give its opinion on unexpected questions that arise." *Id.* at 17a. Thus, although Travelers "could not *resolve* policy questions" (*Community Health Services*, slip op. 12 (emphasis added)), it was acting within the scope of its duties as a fiscal intermediary by offering its advice to petitioner on petitioner's request.

It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

CHARLES FRIED
Solicitor General

DECEMBER 1985